CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

FACTS

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HIV Prevention Community Planning: Successes and Challenges

When did HIV Prevention Community Planning begin and what is the process?

In December 1993, the Centers for Disease Control and Prevention (CDC), working closely with other governmental and nongovernmental partners, issued guidance on HIV Prevention Community Planning to the 65 state, territorial, and local health departments that receive HIV prevention funds. The guidance required these health departments to begin an HIV prevention community planning process in fiscal year (FY) 1994 to qualify for HIV prevention funding for FY 1995 and beyond.

The guidance outlines a process in which the health department administering HIV prevention funds, representatives of the communities for whom the services are intended, and epidemiologists and behavioral scientists work together to identify high priority prevention needs which serve as the basis for health departments' HIV prevention allocation decisions.

What are the core objectives of HIV Prevention Community Planning?

CDC, with national and state partners, has identified five core objectives for monitoring national implementation of the community planning process. These objectives, listed below, encapsulate the most critical indicators of a successful planning process.

- Fostering the openness and participatory nature of the community planning process
- Ensuring that the community planning group reflects the diversity of the epidemic in the jurisdiction and that expertise in epidemiology, behavioral science, health planning, and evaluation are included in the process
- Ensuring that priority HIV prevention needs are determined based on each jurisdiction's unique epidemiologic profile and an HIV prevention needs assessment
- Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, theory (from social and behavioral science), and community norms and values
- Fostering strong, logical linkages between the community planning process, plans, application for funding, and allocation of CDC HIV prevention resources

What successes have been achieved in HIV Prevention Community Planning?

There is no question that community planning has achieved numerous successes since it began in 1994. It is difficult to evaluate a highly decentralized planning system in which state and local groups and their plans are, by design, unique to particular epidemics and appropriate for a variety of target populations. Nonetheless, we have numerous indicators of significant achievement. These include:

Development of planning groups. By 1997, 131 official community planning groups had been developed at the local, regional, and state levels.

Opening up the planning process. The trend toward forming subcommittees and work groups and holding focus groups has helped open up the planning process to more people. Members of the groups report a sense of accomplishment that they are improving HIV prevention programs.

Recruitment of diverse membership. Good progress has been made in recruiting representative membership (53 project areas used mechanisms in addition to group membership to ensure diverse input from persons that reflect the epidemic).

Improved relationships between providers and those at risk. Significantly improved relationships have been developed between health departments and at-risk communities. For example, for the 1997 continuation applications, CDC received 157 letters of concurrence from community planning group co-chairs indicating that health departments had collaborated with the planning groups in developing a comprehensive plan and that the health departments' applications to CDC reflected the priorities in the plan. No letters of nonconcurrence were sent. Also, at-risk communities report more acceptance and ownership of HIV prevention interventions.

Enhancing scientists' understanding of community. Epidemiologists and other social scientists work closely with community planning groups and, in so doing, have developed a greater understanding of community perspectives and needs.

Increasing communities' knowledge of epidemiology. Community planning groups have a clearer understanding of epidemiological data and a more widespread acceptance of its value. The epidemiological profile is the strongest element in the majority of comprehensive plans.

Changing the direction of prevention spending. Clear evidence exists that the comprehensive HIV prevention plans developed by community planning groups have altered budget allocations. Comparing 1993 (before community planning) to 1996 (based on the second year of community planning), the health departments' allocations to health education/risk reduction activities increased from 23% to 37%; allocations to counseling, testing, referral, and partner notification programs decreased from 65% to 37%; and allocations to organizations outside the health department, such as community-based organizations, increased from 46% to 57%.

Affecting prevention activities:
- enhanced prevention activities: increased targeting of programs geographically and in recognition of different behaviors and cultures within at-risk populations
- increased attention to evaluation

– shifts in staffing, community roles, and relationships
– improved coordination of HIV prevention activities
– use of comprehensive plan by outside organizations
– expansion of the planning process to determine priorities for programs and funds beyond HIV prevention cooperative agreement activities

What are the continued challenges for HIV Prevention Community Planning?

HIV Prevention Community Planning represents a change in the way planning for HIV prevention had been conducted. Thus, in addition to the successes community planning has achieved, it is not surprising that the process continues to face challenges. For example:

Meeting technical assistance (TA) needs. The challenge is to meet the increasing demand and tailor the TA to the wide variability of need. In addition, emerging technology changes the prevention landscape, leading to new types of TA needs.

Developing effective regional planning. As more project areas move from a statewide to a regional planning structure, groups will be faced with challenges related to logistics, administration, communications, integrating priorities into a statewide plan without diluting local distinctions, maintenance of representative membership, and need for increased TA.

Increasing the participation of youth. A survey conducted by the National Alliance of State and Territorial AIDS Directors showed that less than 3% of community planning group members across the country were 13-19 years of age. Yet, it is estimated, that 25% of new HIV infections occur in individuals under 22 years of age. The CDC is working with national youth-serving organizations to promote youth involvement in community planning.

Increasing the participation of behavioral scientists. Behavioral scientists are vital in assisting community planning groups in translating HIV prevention research into practical terms, conducting needs assessments, and prioritizing needs. In some jurisdictions, their involvement has not yet reached optimal levels.

Improving the quality of needs assessments. Assessing prevention needs is a critical step in the community planning process. However, needs assessments are among the weaker components of applications.

Sustaining the process. Effective community planning requires sustained commitment from both health departments and planning groups. However, turnover inevitably occurs among both planning group members and health department staff. Therefore, ongoing recruitment, orientation, and mentoring of new members is necessary.

What kinds of technical assistance are available for community planning groups?

To assist in the implementation of community planning, CDC works with its prevention partners to provide technical assistance and training to health departments and community planning groups. CDC provides technical assistance on

- parity, inclusion, and representation of affected populations;
- the use of data to support decision making;
- community planning processes and models;
- needs assessment;
- priority setting;
- intervention effectiveness/what works; and
- conflict of interest and dispute resolution.

This technical assistance is being delivered through a network of governmental, nongovernmental, and private providers. CDC will continue to solicit input on how it can further assist grantees and community planning groups throughout this evolving process.

Community planning groups can make requests for technical assistance through their CDC project officer by calling (404) 639-5230, or through the Academy for Educational Development by calling (202) 884-8862.

For more information...

CDC National AIDS Clearinghouse:
P.O. Box 6003
Rockville, Maryland 20849-6003
1-800-458-5231

CDC National AIDS Hotline:
1-800-342-AIDS
Spanish: 1-800-344-SIDA
Deaf: 1-800-243-7889

CDC National STD Hotline:
1-800-227-8922

CDC DHAP Internet home page address:
http://www.cdc.gov/nchstp/hiv_aids/dhap.htm
